

Accident / Incident Report Closed



Unit/Department	Process Area	Site	Report Number				
South Operation-Elyria	General Catalyst – Building 9	ELYRIA	0084-SOPS-15-0029				
Report Date	Incident Date	Incident Time	Copied From				
03/16/2015	03/12/2015	08:00 PM					
Incident Location	Team Leader / Supervisor	Reported By					
Building 9	Robert Scoggins	Robert Scoggins					
Title of Event (Limit to 90 characters)	Category	Division / Bus. Group / Subgroup Code					
PK Blender outlet valve would not close completely	<input type="checkbox"/> Safety & Health <input type="checkbox"/> Environmental	CC / G-CCP					
Incident Classification							
<input type="checkbox"/> Near Miss <input type="checkbox"/> Property Loss <input type="checkbox"/> Contractor <input type="checkbox"/> Process Safety <input type="checkbox"/> Citation / NOV <input type="checkbox"/> Contractor Injury / Illness <input type="checkbox"/> Injury / Illness <input type="checkbox"/> Health Exposure <input type="checkbox"/> Contract Injury / Illness <input checked="" type="checkbox"/> Spill / Release <input type="checkbox"/> Inspection <input type="checkbox"/> PSM <input type="checkbox"/> Permit / Regulatory Deviation <input type="checkbox"/> Major Incident <input type="checkbox"/> Plant Upset <input type="checkbox"/> Fire <input type="checkbox"/> Non-Occupational <input type="checkbox"/> EHS Management System Failure <input type="checkbox"/> Odor Complaint <input type="checkbox"/> RMP <input type="checkbox"/> Other							
Describe Event / What Happened							
On Thursday March 12 2014, the PK blender operator was in the process of unloading a batch of pill mix. After the first bag was filled, the operator noticed that the blender outlet valve position indicator was still approximately 10% open.							
Immediate Corrective Action or Response							
The operator contacted the floor CRT and the two proceeded to quickly change out the full bag, and install a second bag under the blender outlet. The balance of the pill mix in the blender was emptied into the send bag, with approximately 20-30 lbs of pill mix powder spilling to the floor. After emptying the blender, the operator, CRT and GL went to the 2nd floor and opened the blender to inspect the inside of the vessel. It was thought that perhaps an obstruction within the blender was not allowing the outlet valve to fully close, but no foreign material was found in the blender. The blender was then shut down for the balance of the day/evening; the floor and building were both cleaned up for maintenance and/or engineers to evaluate the issue with the blender valve.							
Immediate Cause							
Unknown...to be investigated							
Spill Release Type(s)	Non RQ Spill / Release						
Chemical(s) Involved	CAS #	Phy. State	Air	Land	Water	Contmt	Units
AL-3917	N/A	Solid	0	25	0	0	lbs
Disposition of Material	Cleaned up						
Weather Conditions	Skies:	Temperature:	Wind Direction:	Wind Speed:			
Cause Narrative							
Operators were not properly trained on how new shut off valve was set up on the blender. The operators were turning the air valve off and not allowing the valve to completely close.							
Contributing Causes		Root/Primary Causes					
Training was incomplete and there was no documentation on the change		163 - Training		170 - Training LTA		175 - On-the-Job Training LTA	
Valve does not fully close when air is turned off.		15 - Design Input/Output		16 - Design Input LTA		16 - Design Input LTA	
Explanation of Root Causes							

175 - A new solenoid was installed however this information was not clear to all of the operators. Once it was reviewed with operators it worked well.

16 - This application needs a fail closed valve to ensure it cannot be opened by residual air in system

Any known or potential off-site impacts?	No	PSM Incident?	No	Estimated Cost:	5,000.00 USD
Investigation Team	Leon Zavodnik; Brian Beller; Terrence M Vanderbosch				

Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	Replace valve with fail close type valve to ensure loss of power will have valve close	Kirk Sullenberger/BASF-CATALYSTS/BASF	09/30/2015	05/15/2015	N	N
2	Label current panel with proper shutoff procedure until new valve is installed	Brian Beller/NA/BASF	06/02/2015	04/23/2015	N	N
3	Modify PK blender Operating procedure and batch sheets once new valve is installed	John Bodmann/BASF-CATALYSTS/BASF	09/02/2015	09/02/2015	N	N
4	Modify PK batch sheets to account for new PK valve on your products	Justin Quach/NA/BASF	09/02/2015	09/02/2015	N	N
5	Train operators on new valve operation	Robert Scoggins/NA/BASF	09/30/2015	09/28/2015	N	N

Approved By:	
Manager / Dept. Head	Leon Zavodnik 04/06/2015 02:43 PM
EHS Unit Coordinator	Dean R Gadoury 04/06/2015 03:33 PM
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